Patient Self-Assessment of Pain

To be completed by the patient at the initial visit and at follow-up visits when past pain has been reported.

Are you having pain related to your visit today?

☐ Yes ☐ No If No, please return this form to the Medical Assistant or front desk.

Do you want to talk to your health care provider about your pain today?

☐ Yes ☐ No If No, please return this form to the Medical Assistant or front desk.

If you've answered "Yes" to both questions above, please complete questions #1-6 below

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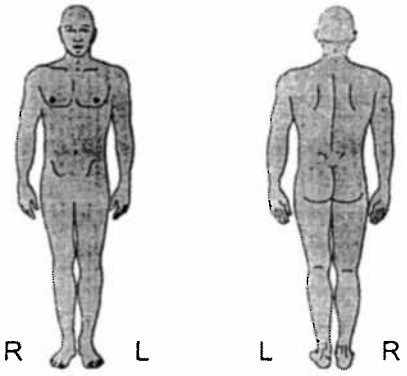
1. **How long have you had this pain?**_____

2. **Where is your pain?** On the diagram, shade the areas where you feel pain. Put an X on the area that hurts most.



3. Below is a scale of numbers you may use to **describe how bad your pain is**:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain Imaginable

My AVERAGE pain over the past 24 hrs

My WORST pain over the past 24 hrs

4. **Circle a word(s) that describes your pain.**

Aching	Sharp
Burning	Shock-like
Dull	Stabbing
Heavy	Tender
Radiating	Other_____

5. **Circle how often you have pain.**

Continuous

Intermittent

6. **What are you doing to decrease your pain?**_____

_____

Signature *(Patient or Authorized Person)*	Date	Relationship, if not patient

Thank you for your responses. Please return this form to the Medical Assistant or Front Desk.
This form is to be placed in the medical record.

☐ Patient Unable to Complete

REVIEWED BY MD - SIGNATURE	DATE	TIME

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

PATIENT SELF-ASSESSMENT OF PAIN

U1690

UH1690 REV SEP 04

PROGRESS – BLUE